



Healthy Living with Diabetes

**Diabetes
Disease Management
Program**

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Background

According to recent reports the incidence of diabetes (type 2) is escalating at an alarming rate with the total number of people with diabetes expected to double by 2010. Diabetes is now the sixth leading cause of death in the United States and the higher rates of cardiovascular, eye, lower extremity, and renal disease among members with diabetes as compared to those without diabetes is well documented. Several studies have conclusively demonstrated that complications from diabetes can be reduced by aggressive glycemic control.

The majority of Molina Healthcare's Medicaid membership encompasses ethnic groups disproportionately represented in the diabetes incidence figures nationally. While diabetes does not represent a top member diagnosis for Molina (largely due to Molina's young population), the costs of diabetes both economically and socially are profound. Recent literature suggests that for every child diagnosed with type 1 diabetes, there is a child diagnosed with type 2 diabetes. The correlation between the increased incidence of obesity and the increased incidence of type 2 diabetes cannot be overlooked. Without optimal glycemic control and adherence to lifestyle changes, this new population of persons with type 2 diabetes will lose productive years of life and suffer needlessly. The time to manage type 2 diabetes among our population is now, in young adulthood, rather than at the inception of complications.

Purpose

Given the diversity of Molina's membership (with over 75% of Latino, African-American or Asian descent), a health management system created around diabetes should improve quality of life among our members and clinical outcomes in the future. Molina's *Healthy Living With Diabetes* disease management program strives to improve outcomes through continual, rather than episodic, care. Providing a continuum of coordinated, comprehensive care reduces the incidence of acute episodes requiring emergency treatment and improves quality of care for our members.

Program Overview

Molina's *Healthy Living With Diabetes* disease management program is a collaborative team approach comprised of patient education, clinical case management and provider education. The team works closely with contracted practitioners in the identification, assessment and implementation of appropriate interventions for non-pregnant adults diagnosed with diabetes.

Goals of Diabetes Disease Management

The goals of diabetes management are to:

- Complete a diabetes self-management program and initiate a personal action plan.
- Maintain (near) normal A1-c or meet established A1-c goal.
- Obtain annual preventive exams and tests (A1-c, dilated retinal exam, urine microalbuminuria, foot exam, and lipid panel).

- Adhere to optimal medication regimen and avoid adverse effects from diabetes medications.
- Initiate and maintain a regular program of brisk walking or other preferred physical activity.
- Prevent acute episodes of diabetes necessitating emergency room visits or hospitalizations.
- Meet members' and families' expectations and satisfaction with diabetes care.
- Support our contracted practitioner network in improving the quality of care with persons who have diabetes.

Diabetes requires long-term, ongoing care to prevent acute episodes and complications and improve members' quality of life. The key components in controlling diabetes are the following: practitioner education and adherence to established clinical practice guidelines, member access to and completion of a diabetes management program, availability of self-management resources, access to member support network, and member-practitioner action plans. The diabetes disease management staff provides education and assists the member and family in the following aspects of the disease management process:

- Importance of a member support network within and around the family of the member
- Pharmacological therapy and routine medical appointments (member-practitioner partnership is necessary to obtain an optimal plan utilizing Clinical Practice Guidelines and member self-blood glucose monitoring results)
- Member education and attainment of self-management skills (knowledge of the disease, compliance with medications, self-monitoring skills, communication with practitioners, development of a personal action plan related to meal planning, and exercise.)

Program Eligibility Criteria and Referral Source

The *Healthy Living With Diabetes* program is designed for Molina members with a confirmed diagnosis of diabetes (non-gestational and/or non-steroid-induced). The member shall participate in the program for the duration of his or her eligibility with the plan's coverage or until he/she opts out. The proposed program model is an "opt-out" design, so members remain in the program unless they ask to be removed from the registry.

Multiple sources are used to monthly identify the total eligible population including but not limited to:

- Pharmacy claims data for all classifications of diabetic medications
- Encounter data or paid claim with an CPT or ICD-9 code indicating a diagnosis of diabetes
- Lab results data (HbA1C, microalbumin, creatinine)
- Member Services – welcome calls made by staff to new member households and incoming calls have the potential to identify eligible members. Eligible members are referred to the program registry.
- Practitioner referral
- Case Management or Utilization Management review for an eligible member
- Member self-referral – general plan promotion of program through member newsletter and other member communications
- Nurse Advice Line services and other sources of member/practitioner contact whereby identification and referral is possible.

Program Components and Stratification

The *Healthy Living With Diabetes* program has two foci of intervention, member directed and practitioner directed. The components of member directed interventions are member education and high risk case management. Practitioner interventions include the development and dissemination of guidelines, promotion of the program to practitioners, notification of identified members to assigned PCPs and the dissemination of member profiles.

Member Education (Patient Education and Clinical Case Management)

Once members are identified for the diabetes registry all known clinical data is entered into the database registry to assist with the stratification process. Additionally, member responses to a quality of life assessment conducted during initial outreach to the member are also used to determine appropriate stratification, and thereby identify the most appropriate resources and interventions.

Risk stratification results in member assignment into one of three levels (low, medium and high). The intensity of outreach efforts and education increase with each level. If at any time a member requires a higher level of care, a referral is made to Clinical Case Management.

The focus of program interventions is to ensure the member understands key self-management concepts and has the resources to implement them. All education is consistent with the National Diabetes Education Guidelines and American Diabetes Association standards for diabetes self-management. Each identified member receives specific educational materials and other resources in accordance with their assigned stratification level. Additionally, all identified members receive periodic educational newsletters. A standardized chart note, reflecting all educational objectives met, is forwarded to the member's primary care physician (PCP) for inclusion in the member's medical record.

Low Level Interventions

- Member mailing includes a welcome letter, educational brochure (*Getting Started with Your Diabetes*), diabetes assessment to complete and return via prepaid mail
- Educational newsletters/mailings 2-3 times per year
- Telephonic counseling available at member's request

Medium Level Interventions

- Member mailing includes a welcome letter, enhanced education kit, a diabetes assessment and a prepaid return envelope
- Development of a personal action plan
- Educational newsletters/mailings 2-3 times per year
- In addition to diabetes-specific education, other educational resources such as weight management and smoking cessation services might be offered as appropriate to the member's assessment and readiness to make behavior changes
- Telephonic counseling available at member's request

High Level Intervention

- Initial contact assessment includes:
 - Outbound call from Care Manager to members to complete the diabetes assessment

- Evaluation of member health status, medication compliance and general quality of life
 - Assessment of member learning preferences and needs to determine the most appropriate interventions (hospital based group program, individual appointments with a diabetes educator or telephonic education with an educator)
 - Upon completion of the diabetes assessment, members are mailed a welcome letter and an enhanced education kit.
 - In addition to diabetes specific education, other educational resources such as weight management and smoking cessation services might be offered as appropriate to the member's assessment
 - Individualized care plans are developed for each member and may include a nutritional assessment and meal plan completed by a registered dietitian
 - Members with identified co-morbid medical conditions are referred for screening by clinical or medical case management.
- Ongoing contact includes:
 - Periodic telephonic outreach to assess member health status and continued learning/resource needs; frequency of outreach determined by member status
 - Adjustments to individualized care plan as necessary
 - Referral to medical case management as necessary
 - Educational newsletters/mailings several times per year
 - 6-month assessment includes:
 - Care manager reevaluates member's health status and general needs utilizing a subset of questions from the initial diabetic assessment
 - Revisions to care plan as necessary
 - Upon completion of the educational objectives, members are referred to clinical case management for review and potential co-management. Case management coordinates care for these members, involving other members of the team as appropriate.

The goal for all levels of member education is increased member self-efficacy related to diabetes management. Additionally, behavioral outcomes are determined on an individual basis for medium level and high level members to increase exercise, improve meal patterns, and/or improve adherence to their medication regimen. Selected responses from the assessment instrument will be reported at baseline and three to six months post intervention. Members are encouraged to set individual goals and report progress to their PCP regularly. These members have written contracts that will ideally evolve over time. All members are instructed in self-blood glucose monitoring (SBGM) and encouraged to test in accordance with physician instructions, unless the PCP does not wish for member to test at home.

Clinical Case Management

The role of clinical case management within the diabetes program is for provision of short-term acute interventions that may be needed in order for members to be successful with the goals of the overall diabetes program. This may involve managing an acute co-morbid condition and facilitating services for the member through the health care continuum. The case manager will collaborate with other team members as appropriate including the treating physician(s), health education/health management staff, and/or other ancillary services staff as needed.

Through the use of a secure data platform, Molina Healthcare's clinical case managers efficiently and effectively assess individual member needs and learning preferences, conduct interventions, including medication therapy management and member mailings, and track all encounters. The data platform also houses all disease-associated inpatient, outpatient and pharmacy claims incurred by the member during the preceding twelve months. Case managers track member progress in health management programs and share this information with primary care physicians and other internal departments as appropriate to ensure continuity and coordination of member needs. The data platform creates a single integrated system that provides users with timely access to member information so that interventions match the severity of the member's condition.

Practitioner Education and Program Involvement

To ensure consistency in the approach of treating diabetes and with the participation of practicing physicians, Molina developed clinical guidelines and pathways for diabetes management. These guidelines originate from national guidelines established by the American Diabetes Association Guidelines for the Diagnosis and Management of Diabetes. Their purpose is to serve as a basis for the medical treatment of diabetes by network practitioners. Guidelines are distributed to contracting practitioners at least annually and are posted on Molina's webpage. Other resources and tools are distributed to practitioners to enable ongoing management at the physician's office. These may include diabetes flow sheets, co-morbidity reminder stickers, HEDIS reminders, monofilament and foot exam posters, and patient education (topic-specific) flyers. Through the dissemination of these resources Molina seeks to meet a primary goal of the program which is supporting our contracted practitioners.

Practitioners are informed about the program via routine health plan communications such as *Just the Fax* weekly electronic publication, the *Partners in Care* physician newsletter, CMEs, and Joint Operation Meetings. A program promotional flyer, focused at physicians, is utilized for this purpose.

Twice annually all PCPs are mailed a list of members assigned to them who have been identified as having diabetes and being eligible for the program. Additionally, at least once each year individual member profiles are mailed to PCPs that include program enrollment, stratification level, all known encounter information relating to the diabetes diagnosis and member assessment responses as appropriate. For all members stratified to high risk, PCPs are also sent copies of the member completed diabetes assessment for inclusion in the member's medical record and physician consideration in the member's overall treatment plan.

The disease management program supports the practitioner practice by providing education and other resources to members to assist them in achieving optimal self-management knowledge and skill. All participants are referred back to their PCP regarding clinical care issues. The role of disease management is to support and assist the primary care physician in achieving quality health outcomes around diabetes care.

Program Evaluation

To evaluate effectiveness of the program, the following measures will be used:

1. Comprehensive HEDIS measures
2. Increase in self-blood glucose monitoring
3. Pre-post self-efficacy changes in actively enrolled participants
4. Pre-post behavioral changes in actively enrolled participants
5. Member satisfaction with the program

The Quality Improvement Strategies Committee provides direction and oversight of the program. An annual program evaluation is completed and reviewed by the committee for improvement and/or enhancements. Additionally, annual reports are discussed at the Quality Improvement Committee and Clinical Quality Management Committee for comment and ongoing recommendations.